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ABSTRACT

Detailed are the functions, structure, and relationship to data gathering systems of an interdisciplinary team habilitation approach in a residential center for mentally retarded persons. Deficiencies of the system currently in operation at Willowbrook Developmental Center (New York) are reviewed. It is explained that suggested reorganization is based on the case team approach with each member designated case manager for certain residents. Stages of team functioning are described, and an individual case is traced through the four stages (case team assessment, treatment team consolidation, program implementation, and resident evaluation). Also considered are such implementation factors as provision for case review, participation by therapy aides on case teams, and strategies for phasing in the new system. (CL)

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Interdisciplinary Team Functioning: A Case Team Approach to Habilitation in a Residential Facility for the Mentally Retarded

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Willowbrook Developmental Center

June 1975

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Staten Island, N.Y.

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Preface

This paper is a result of a project begun in November 1974 at the request of Mr. James J. O'Hora, Chief of Service, Unit X, Willowbrook Developmental Center. It was the recognition by the Chief of Service that the level and quality of programming activity within the unit could be more efficiently utilized that led to the studies resulting in this and other reports and proposals for the refinement of interdisciplinary team functioning and innovations in clinical data management.

Among the factors weighed in undertaking the present study was the great deal of confusion and ambiguity regarding the roles and interactions of professionals vis-a-vis interdisciplinary functioning, and the lack of an efficient and comprehensive method for the management and use of habilitative data. This report is an attempt to deal with the topic of an interdisciplinary approach to the habilitation of the mentally retarded by specifying the pitfalls involved in such functioning and by suggesting organizational modifications that will result in an efficient and workable model for such an approach. Although not intended as an exhaustive study of the topic, this paper should provide the basis necessary for a hard look at, and possible reorganization of, the current structures and practices involved in the delivery of habilitation services in a residential facility for the mentally retarded. It is expected that this will be the first of a series of reports on the design, application, and evaluation of a model for interdisciplinary team functioning and the implications of such a model for such diverse clinical and administrative functions such as data management, organizational structure, manpower studies and projections, and the evaluation of treatment units of delivered service.

June 1975 H.M.Z.

Interdisciplinary Team Functioning: A Case Team Approach to Habilitation in a Residential Facility for the Mentally Retarded

Introduction

Much has been written on the importance of an interdisciplinary approach to the habilitative treatment of the mentally retarded. However, a survey of the literature concerned with the use of innovative structural and functional aspects of treatment planning, program implementation and evaluation, and assessment of habilitation, reveals that sparse attention has been given to the practical problems of the administrative aspects which must be evolved in a residential facility so that an interdisciplinary approach becomes feasible and workable. Authors have continually extolled the virtues of interdisciplinary functioning but few, if any, have published any guidelines for the implementation of such a system or any suggestions on how to stimulate and maintain the flow of interdisciplinary communication.

Among the more recently published authoritative works in the field of mental retardation, several do not as much as even index the topic of interdisciplinary team functioning (Baroff, 1974; Baumeister and Butterfield, 1970; Clelland and Swartz, 1969). Indeed, one of the few plans the present author has seen (Decker, 1970) is a spin-off from a system of health care delivery in institutions for the mentally retarded. Decker's plan for comprehensive health care proposes a model of interdisciplinary functioning that has provided one of the key concepts

for the system to be developed here. The idea, advanced by Decker, that for interdisciplinary team functioning it is not necessary to have every discipline participate in the primary assessment of the client, is put forward as one of the main axioms of the present system. Aside from Decker's monograph, almost no definitive literature on the structural and functional aspects of interdisciplinary team functioning is currently available.

A sharp distinction must be made between a multidisciplinary approach and an interdisciplinary approach. Webster's (1963) defines 'multi-' as many or more than one and defines 'inter-' as meaning between, among or within individual elements. To paraphrase Wolfensberger (1970) writtng in a slightly different context - an interdisciplinary approach is to be distinguished from a multidisciplinary approach in which several disciplines work parallel to each other in the same setting, rather than with each other on the same problem. The presentation by Koch and Dobson (1971a) is a prime example of this distinction. Although they state that the development of the book was stimulated by interdisciplinary groups working in health and education, (page ix) the work is completely multidisciplinary in its approach. The discussion of team functioning (Koch and Dobson, 1971b) is strictly an outline and description of parallel diagnostic and treatment planning services and does not even appear to consider the possibility of interdisciplinary functioning.

In a discussion of psychiatric roles in mental retardation, Menolascino (1970) alludes to the importance of generalist functions in the

diagnostic and treatment aspects of mental retardation. Although his view is thoroughly grounded in the multidisciplinary model, he voices the concern that all professionals must work together to bridge the gaps in the current pattern of service programs to the retarded. Beitenman (1970) appears to extend the primitive concept of the multidisciplinary team to its next logical step. Although based on a model of parallel disciplinary functioning, he advances the idea of a coordinator of team members roles. Without actually acknowledging the concept of interdisciplinary functioning, he implies that the role of the team coordinator would be generalist in nature and that the individual in that role would have the responsibility for the intergration of treatment services.

Balthazar and Stevens (1971), in an analysis of the multidisciplinary treatment systems commonly utilized in residential facilities for the mentally retared, note that the failure to implement true interdisciplinary functioning is "...essentially the failure to communicate between disciplines and the exchange of information." This, they reason, is responsible for "...a failure in the mutual interaction between various clinical services to attain desirable programs for the resident." (p. 4) They further maintain that administrators, more often than not, find themselves engaged in dialogues with various clinical services where interaction and reciprocity are the exception rather than the rule. Although clearly noting the crucial need for a common language to circumvent semantic barriers between the professions, Balthazar and Stevens fail to address themselves to any of the administrative

aspects inherent in any scheme to stimulate, increase, and maintain interdisciplinary communication and interaction. It would appear patently obvious to this author, that their recommendation for a common language base and their fervent hope that this will produce meaningful interdisciplinary planning and programming is but a futile exercise since they do not address themselves to the structural elements of current administrative and clinical functioning that clearly hamper the removal of disciplinary boundaries.

Clearly, interdisciplinary team functioning implies the evolution of the professionally trained specialist into an interdisciplinary generalist with specialized skills to be used in conjunction with other treatment modalities. The concept also implies that treatment planning, program implementation and evaluation, and assessment of habilitation, are carried on with the joint input and participation of all treatment modalities and in a manner capable of stimulating and maintaining a high degree of interdisciplinary communication, interaction and cooperation. It follows then, that a system for the efficient use and management of interdisciplinary information becomes a necessary prerequisite for effective team functioning. As the various components of the data system are described in another report (Zweig, Note 1), this paper will address itself to the detailing of a suggested interdisciplinary team structure, its functions, and its relation to the data management system.

Insert Figure 1 about here

Team functioning as it has evolved here at Willowbrook is graphically illustrated in Figure 1. A study of this diagram reveals several structural aspects which clearly hamper effective interdisciplinary functioning. Under the current multidisciplinary model, a professional specialty tends to deal with a resident only from its own point of view and only when the resident has been referred and is being considered for programming by that specialty. Rarely, if ever, is a resident seen by a specialist who is not considering the possibility of adding him/her to the specialist's caseload. Indeed, even when residents are seen for evaluation when no vacancy exists on the caseload, the report to the treatment team usually concerns the residents needs vis-a-vis that particualr speciality, and infrequently refers to areas traditionally considered outside of the specialists area of expertise. The current tendencies to premit professional "turfs' to continue to exist and to permit assessments, programming, and evaluations to take a disciplinary format (even when presented at an interdisciplinary conference) continue to encourage professional specialists to maintain themselves only within their own fields and hampers their development into interdisciplinary generalists.

Another apparent defect of the current system is the lack of any structured means of interdisciplinary communication, data gathering or information sharing. In short, the team as it functions now, lacks a common language on which specialists can base generalist communications and interactions. The current system of data gathering, i.e.,the progress notes that are centrally filed by each individual discipline also

continues to maintain a specialty's boundaries rather than encouraging a generalist approach. Similarly, the current team structure fails to provide any established method of cross-modality assessment of the client. These limitations appear to render any attempt at true interdisciplinary functioning, highly desirable but almost impossible to achieve.

In order to remedy many of the defects of the current structure, a complete reorganization of team member relationships and functions is outlined in this paper. The reorganization of the structural and functional aspects of treatment team operation will not only counter the effects of the defective structural aspects already discussed above, but will also result in several other highly desirable outcomes. In addition to resulting in more effective interdisciplinary functioning, the suggested reorganization incorporates the basis of an advocacy system; provides the mechanism for obtaining accurate and up to date data for administrative purposes such as manpower projection, budget planning and numerous surveys of client services; and incidently provides for compliance with those sections of the consent decree concerned with team functioning and record keeping.

Insert Tables 1 & 2 about here

Insert Figure 2 about here

The Case Team Approach

The proposed reorganization is based on the restructuring of current therapeutic personnel into small, compact, interdisciplinary groups called case teams. Although, for purposes of illustration we will deal here with the present therapy staff in Building 15, the principles presented here are general in nature and as such can be applied with equal ease to other settings and situations. Table 1 presents a breakdown of the current therapeutic personnel of Building 15 by discipline and professional status. The two Long Island University physical therapy students are noted but they are omitted from the total staff count as their assignments within the unit are only temporary. The reorganization of staff into four case teams is detailed in Table 2 and is functionally diagrammed in Figure 2. Several principles used in the construction of the case teams are immediately apparent: a) no one case team contains members from all the disciplines involved in the larger treatment team; and b) no case team contains more than one representative from any particular discipline. These two conditions tend to increase the probability that a) residents will be evaluated by individuals who may not be concerned with the actual rendering of a particular professional service, so that the scope of the assessment will be broader and more general in nature; b) no case team assessment will be biased in the direction of one specialty; and c) case team members will be forced to pool all information and sort the data from a generalist viewpoint in order to produce a meaningful set of habilitative treatment recommendations.

It is also apparent from Figure 2 that impetus is given to the elimination of boundaries between the specialties and a maximum degree of interdisciplinary communication, interaction and cooperation is provided for.

The establishment of the case team does not replace the treatment team either structurally or functionally. Indeed, case teams are considered to be intergral components of the larger treatment team. The case teams are mandated to present their reports to the full treatment team for discussion and ratification of their recommendations. By establishing only four case teams as illustrated, it is possible to schedule one case team meeting per day and to schedule the meeting of the full treatment team on the fifth day. By limiting the compostion of a case team to only one member from a specialty, it is possible in most instances for therapies to continue without any major disruption of caseloads.

The Case Manager

Another important concept in the reorganization of treatment team functioning is the designation of case team members as case managers with the responsibility for coordinating case team operations vis-a-vis particular clients and having the responsibility of preparing the Narrative Summary and the report to the treatment team. As such, each team member will become the case manager for a number of residents for whom he would be required to exercise some degree of supervision over their habilitative programs. He or she would also have the direct responsibility for following up the implementation of treatment plans for his clients and would be charged with the preparation of the quarterly progress summaries.

For the purpose of illustration, let us assume the establishment of four case teams in a building whose current census is 127 residents. This would yield an assignment of approximately 30 residents per case team. The assignment, then of each of the four case managers on any one case team would be only eight residents for whom the case manager would be required to coordinate the assessments, prepare the Narrative Summaries, report on to the full treatment team, provide follow-up on program implementation and prepare Quarterly Progress Summaries.

Stages of Team Functioning

What follows now is a detailed outline of interdisciplinary team functioning utilizing the concepts of the case team and the case manager. Team functioning, for the purpose of ease of presentation, has been divided into stages based on the four major component activities inherent in this approach to treatment planning and habilitation. Figure 3 illustrates these four stages and alludes to the interrelationships between them. These stages, the functions they encompass, and the flow of data between and through them will be elaborated on below with a more complete description and a detailed flow chart of each. For the purpose of an overview, however, a very brief description of each stage is presented here.

Insert Figure 3 about here

Stage 1 - Case Team Assessment. A framework for the case team assessment of the resident is presented. The team sees the resident,

gathers other data about him/her and pools its information at a meeting. The case manager integrates the material, prepares a written Narrative Summary and prepares the case for presentation to the treatment team.

Stage 2 - Treatment Team Consolidation. The case manager presents the integrated report to the treatment team along with recommendations for habilitative programming. The treatment team may modify the recommended programming if they so choose. A date is set for the residents next case team assessment and treatment team presentation.

Stage 3 - Program Implementation. Residents are referred for therapy as per the treatment team's decisions. They are either placed on caseloads or waiting lists and their status is noted.

Stage 4 - Resident Evaluation. A framework for the evaluation of the resident's habilitative progress is presented. This evaluation is based on a system of progress notes integrated by the case manager into a Quarterly Progress Summary. Paths for various therapeutic outcomes are outlined and specified.

Team Operation - Stage 1

For purposes of illustration and ease of presentation let us trace an individual case through our proposed system of team structures and functions specifying the component interactions and the relationship to the habilitative data system. Case A is scheduled to be reviewed by the full treatment team in about two weeks. Upon scheduling the review. the team leader notifies the building physician to prepare the Medical Summary and to forward it to the case team. The team leader also notifies the case team and designates a case manager if the client does

not already have one. Case team members, under the coordination of the case manager, must observe the resident during the various activities in which he/she is engaged in. Similarly, the case team members will refer to the past history, the available progress notes, the Medical Summary and will consult with any indiviudal whose expertise would have a bearing on the case. Although a particular case team may elect to divide the workload of any one assessment among themselves, it is extremely advisable that each team member be required to directly observe some aspect of the resident's program so that every team member will have some first hand knowledge of the resident's status and capabilities.

Following this active period of direct observation, research and consultation by the various case team members, the resident will be discussed at the case team meeting attended by all case team members and the therapy aide involved with that resident. The objectives of the meeting are the integration of the gathered data, the outlining of areas for habilitative programming and the specification of behavioral goals for each program area. The case manager assigned to the case acts as a chairperson for this discussion and is charged with producing a written Narrative Summary of the clients current status based on the concensus of the case team. He or she is also charged with integrating the gathered data and recommendations into a report to be presented to the full treatment team conference. This process is graphically illustrated in Figure 4. It will be noted that the Medical Summary and the Narrative Summary are component documents of the data system and are routed to the resident's profile on both the unit and team levels.

Insert Figure 4 about here

Insert Figure 5 about here

Team Operation - Stage 2

Illustrated in Figure 5 the Treatment Team Consolidation Stage presents the flow of the clients case through the full treatment team to the program implementation stage. During the treatment team conference (normally a two hour meeting) a time slot of about 15 minutes is allotted for the presentation and discussion of each case. (For our purposes a 15 minute time slot per case has been arbitrarily allotted so that approximately eight cases may be presented and discussed at one meeting. It should be obvious that the treatment team can alter these specifications at any time.)

In essence the treatment team conference provides a forum for the presentation of the case team's findings and recommendations for programming. Chaired by the Team Leader the treatment team - with its wide and more complete range of disciplinary input - after presentation by the case manager weighs and processes the appropriateness and the therapeutic soundness of the case team's findings and recommendations. In this sense, the treatment team functions as sort of a governing body with full control over programming and habilitation.

Case A then is presented to the full conference by the case

manager who will have integrated all the findings and recommendations into a coherent and comprehensive report. He will present, in detail, the recommendations for programming and their rationale before opening the floor for discussion. Following the discussion approval of Case A's habilitative program is called for. If approval is not forthcoming, the treatment team may alter and modify the program as it sees fit so that a consensus may be obtained. Once the program is approved, the case manager completes the Habilitative Program Record and forwards it to the Team Leader for filing on both the unit and team levels. The treatment team case manager and the Team Leader, at this point, schedule the next case team and treatment team reviews of Case A. A master schedule is maintained for this purpose by the Team Leader who retains the over all responsibility of coordinating evaluations, case and treatment team agendas and the quarterly review schedules.

Insert Figure 6 about here

Team Operation - Stage 3

The Program Implementation Stage as diagrammed in Figure 6 is basically a routing procedure for the programming developed by the case team and treatment team. The first step in the implementation procedure is the issuance of service orders or requisitions by the Team Leader to each of the therapies that were recommended for Case A by the treatment team conference. These service orders are sent by the Team Leader to the supervising or senior therapist in each discipline.

orders be responded to in writing within a given period of time so that follow through of client services can be accurately documented.

As is apparent from Figure 6, there are only three options available to the supervising therapist vis a vis the placement of a resident on a service. A) The resident is placed on a therapeutic program without any modifications of goals or program methods - in this case the Team Leader is notified of the action and nothing further occurs in this stage. B) The resident is placed on a therapeutic program but the supervising therapist finds it necessary to alter or modify some aspect of the program methods or goals - in this case the Team Leader and the case manager are notified of the changes and the case manager records the modifications on the Program Record. C) The client is not placed on a therapy program - at this stage the only justifications for not servicing a given resident would be the lack of personnel or the lack of specialized equipment. The contention that the resident is not suited for therapy is not to be accepted as the appropriateness of a particular recommendation is to be decided during the Treatment Team Consolidation Stage and it is hoped that disciplinary judgements regarding the soundness of a given recommendation will be made public during stage 2. When a resident is not placed on a recommended therapeutic caseload the supervising therapist notifies both the Team Leader and the case manager. The Team Leader places the resident on a waiting list for that particular therapy and as such maintains the mechanism

for recirculating the resident through the implementation process. The case manager is responsible for noting the waiting list status on the resident's Program Record.

Insert Figure 7 about here

Team Operation Stage 4

Stage 4 is schematically diagrammed in Figure 7 which details the evaluative process to be used to monitor the progress and rates of progress of clients involved in habilitative programs. It is the mechanism which will ensure full accountability by each professional or paraprofessional involved with a particular client by providing for an accurate data gathering procedure that will be monitored by an individual other than the therapists generating the information. As such, therapists will be expected to maintain their daily and weekly progress notes in a coherent format so that the information thus gathered will provide a clear concise and complete record of the resident's progress or lack of progress towards the goals mandated by the treatment team.

Assuming that Case A has been placed on therapy program A as indicated in Figure 7 progress will be monitored daily by having the therapist involved rate the residents observable behavior with respect to the goals and sub goals specified in the Habilitative Program Record. Such monitoring will be incorporated into a system of daily progress notes (to be kept and filed by the therapist) and a system of weekly progress notes (to be kept by the therapist and filed at the team level.

The weekly progress notes will be an overview of the weeks activities with respect to the very specific behavioral goals outlined in the Habilitative Program. Consider then that Case A, after what the therapist considers a reasonable period of time, has not met the program goals or sub-goals. Figure 7 indicates that the supervising therapist in that discipline would conduct a review of the program with the aim of either continuing the program as is or possibly suggesting suitable modifications based on the residents performance. Should the supervisor not alter the program specifications, the resident is merely recycled through the therapy process. However, if modifications are suggested the resident is cycled through the program modification procedure of the implementation stage and is then fed back down to the evaluation stage. This procedure is clearly outlined in Figure 7.

In either case, this whole process is noted in the daily progress notes which provide the data base for the weekly team level notes. The weekly progress notes in turn provide the data base for the Quarterly Progress Summary to be prepared by the case manager. It is at this point that evaluation by an indiviudal (the case manager) not directly involved in Therapy Program A is introduced into the evaluation scheme of the resident's progress. This procedure provides for a review of the resident's progress by an individual who is functioning as a representative and advocate of the resident and involved in monitoring his or her overall progress. The case manager is charged with the preparation of the Quarterly Progress Summary, which will be an evaluative statement of the residents progress vis-a-vis the specific goals.

contained in the Habilitation Program. It should also be pointed out that the weekly notes and the quarterly summaries provide much of the data base to be fed back into the assessment stage thus providing the information necessary for the next cycle through the assessment and program planning processes.

Implementation of the Case Team Model

There are several factors for which strategies must be developed prior to the implementation of the case team model. Among these factors that should be considered are a) the current method of case review - Form 33 DMH; b) the role of the therapy aide vis a vis the case team; c) consideration of the allotment of time to staff for adequate recording of data; d) the assignment of backup case managers; and e) the development of a strategy for phasing in the new system. This paper will now attempt to put forward some comments regarding the above topics which may prove helpful in the development of an implementation plan.

Case Review - Form 33 DMH. At the present time, component units of the New York State Department of Mental Hygiene (DMH) are mandated to provide review of a client's status and programming at six month intervals. Scheduling of a review is accomplished by assigning clients for review by the month in which they were born. This provides for a rotational system in which a client is reviewed during his/her birth month and again on six months from that date. The present rotational system is adequate for the moving of residents into the new cycle of operation and will allow for all the residents in a building to be

integrated by the new system within a period of six months. However the current method of scheduling remains relatively inflexible regarding the specified interval between reviews. It is to be expected that the treatment team may require that a resident's progress be monitored and reviewed more often than once in six months. In such it is suggested that the current rotational system be used to feed clients into the new system but that once the initial input is made, the rescheduling of reviews should be done independently of the WSH review calendar. Information necessary for the completion of Form 39 D'H will be readily accessible in the residents profile and could be entered onto the form either by the team leader or the case manager without the necessity of having to schedule a meeting for this purpose. Provided that an outside limit of six months is placed on the length of the interval between reviews, the information available in the resident's profile will almost always be current and up to date.

Therapy Aide Participation in Case Teams. Therapy Aide participation is vital to the entire treatment process in as much as the therapy aide possesses the most indepth and complete knowledge of those residents placed in his/her care. As such the therapy aide is not only a valuable source of detailed information but becomes an integral part of treatment effort by providing continuity of the therapeutic regimen to the ward.

Given the present system of resident grouping (i.e. by functional treatment goals) the present D'H method of scheduling case reviews and the need to be able to equitably distribute workload among the

various case teams during the period of feeding the cases into the new system, it appears unlikely that a particular therapy aide and his/her group of residents would be exclusively assigned to participate in the proceedings of only one case team. It would be most desirable to have a therapy aide consistently work and participate with the same case team since this would result in a far less complicated series of interactions and interrelationships between the therapy aides and the various case teams. Unless and until some modification of either the method of grouping residents or the method of scheduling case reviews, therapy aides will have to be temporarily attached to a case team whenever one of his or her residents is being reviewed.

It is suggested that in order to establish a more permanent liaison between the therapy aides and the case teams, ward supervisors should be assigned as fully functioning members of a case team in addition to the temporary assignment of therapy aides. This would help to spread the workload, provide for valuable input from the ward staff and also help to provide the ward supervisors with valuable experience necessary for possible career advancement.

Time Allotments for Record Keeping. Accurate record keeping is a time consuming procedure that will have to be included in each therapists daily schedule. By building this consideration directly into the system of operation we can ensure the accountability of the therapy staff for these necessary data generating functions. Although it is beyond the scope of this paper to be able to accurately specify the time necessary for a therapist to be able to competently record a progress note, it

does seem reasonable to assume that anywhere from one half to one hour per day would be adequate. To be sure this estimate could be adjusted as the various therapies evolve efficient methods of recording clinical material in behavioral terms.

Back up Case Managers. In order to allow for the anticipated or unanticipated absence of case managers either due to sickness, vacations or other forms of leave or time off, it is suggested that backups be assigned for each case team member. The backup manager would be required to accquaint himself/herself with the backup caseload so that he/she could intelligently discuss a particular resident when and if the case manager is absent. This would require a working knowledge of a second caseload without the concomitant case managerial responsibilities beyond a sometimes transient requirement to present a case to the treatment team. In order to allow for the maximum opportunity for familiarization with a second caseload it would probably be most efficient if backups were assigned from within the particular case team. This would ensure the probability that the backup manager will have some first hand knowledge of the backup caseload as he/she will have been required to spend some time in observing each resident assigned to his/her case team.

Strategy for Phasing in the New System. It is not within the scope of this paper to discuss specific strategies as these are only now being developed. However it is reasonable to assume that the following are the steps to be undertaken in the development of an implementation strategy.

1) The dissemination of the basic plan to upper and middle level management personnel.

2) The dissemination of the plan to the targeted building treatment teams.

3) The assignment of therapeutic and ward personnel to case teams.

4) Designation of the first round of case manager assignements.

5) Establishment of a series of workshops, meeting on the case team schedule and using the initial case assignments as illustrations, to acquaint the staff with the roles and functions of the case teams and case managers.

7) The presentation of an interim progress report to the chief of service following the completion of the workshop series.

Reference Note

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Footnotes

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Table 1

Current therapy staff distribution of Building 15

	Paraprofessional assignments	Professional assignments
Medical	-	1
Nursing	-	3
Psychology	-	1
Speech	-	1*
Physical Therapy	4	(2)**
Occupational Therapy	2	-
Education	2	2
Recreation Therapy	-	2

*Actually .5 FTE.

**Temporarily assigned L.I.U. masters program students

Table 2

Sample case team compositions using current building 15 therapy staff.

Case Team 1	Case Team 2	Case Team 3	Case Team 4
Rec. Ther. 1	Rec. Ther. 2	Occp. Ther. 1	Occp. Ther. 2
Teacher 1	Teacher 2	Teacher Asst. 1	Teacher Asst. 2
Phys. Ther. 1	Phys. Ther. 2	Phys. Ther. 3	Phys. Ther.3
Speech & Hearing	Nurse 1	Nurse 2	Nurse 3
(Ward Supervisor 1)	(Ward Supervisor 2)	(Ward Supervisor 3)	

Figure Captions

Figure 1. Traditional multidisciplinary team structure. Note the horizontal compartmentalization of specialities.

Figure 2. Proposed interdisciplinary team structure based on the case team approach to habilitation.

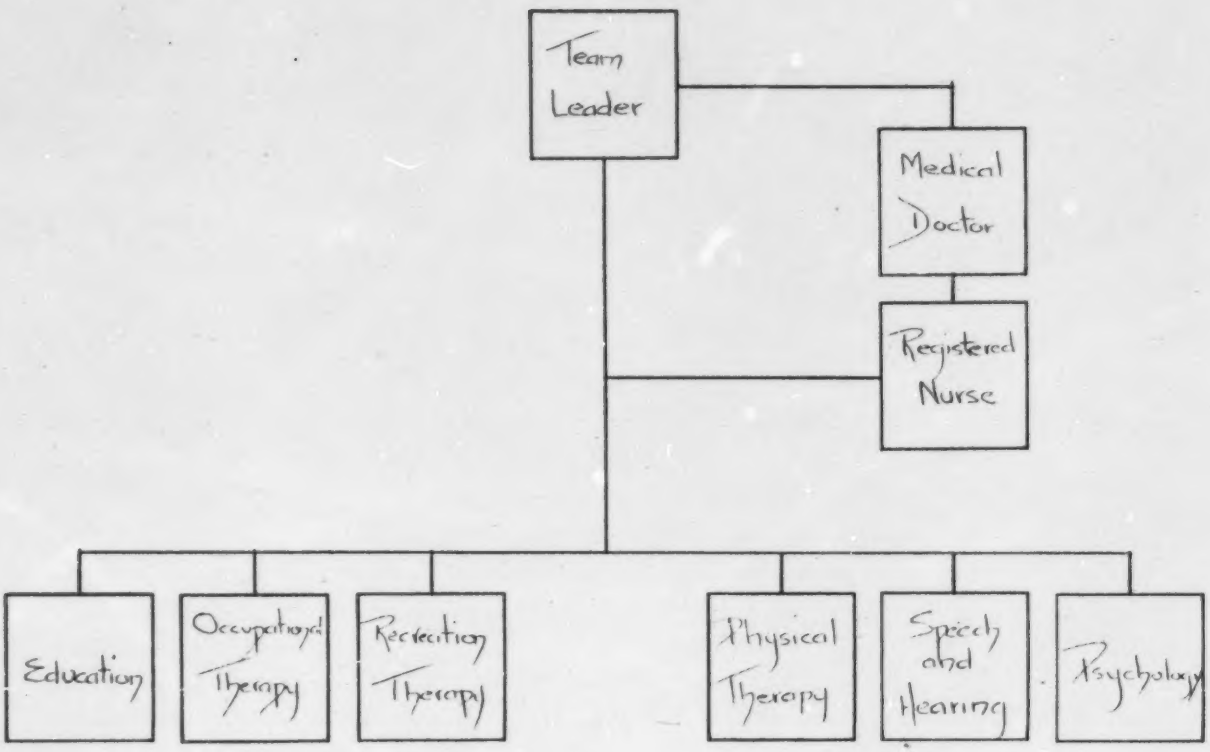
Figure 3. Overview of the four stages of team functioning illustrating the relationships and feedback flows between the stages.

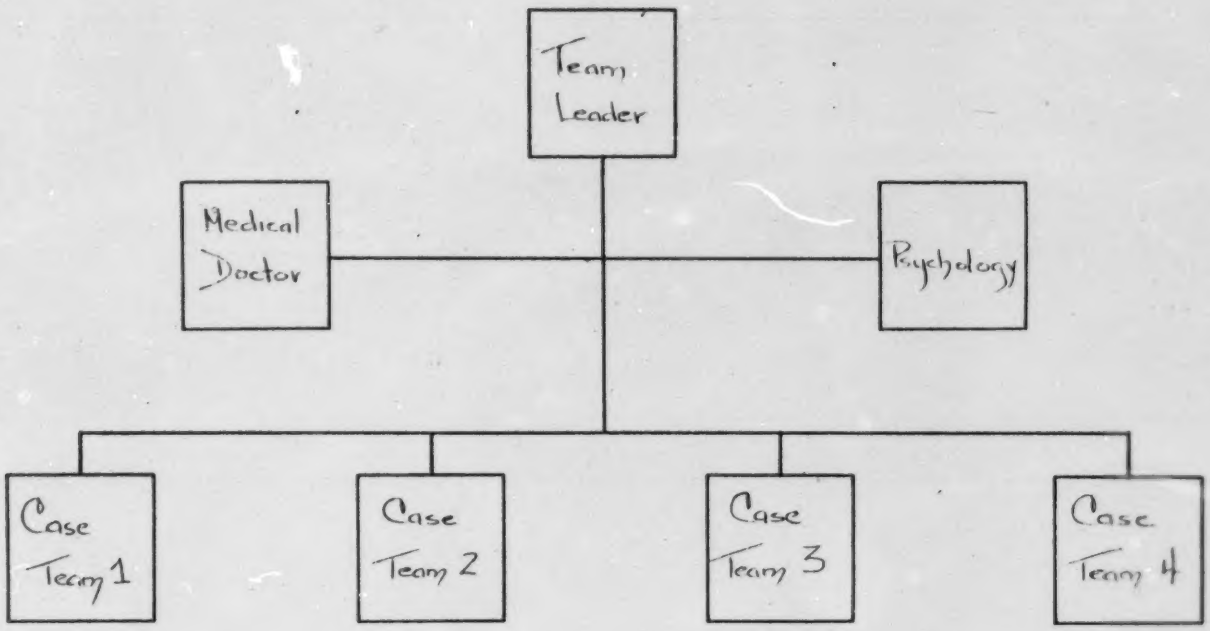
Figure 4. Team Operation - Stage 1. The case team assessment stage.

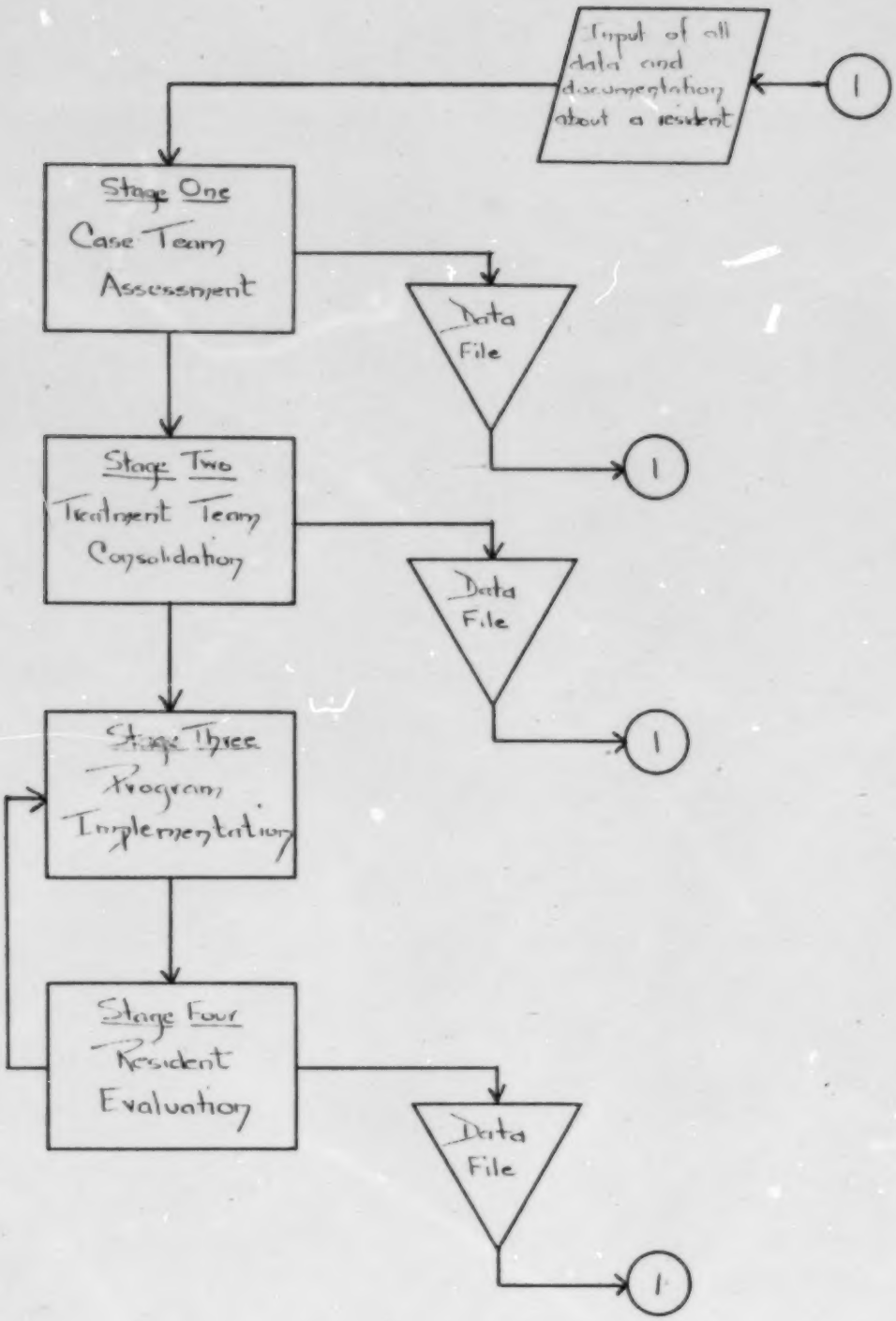
Figure 5. Team Operation - Stage ~~2. The treatment team con- 3. The program implementation stage.~~ 2. The treatment team consolidation stage.

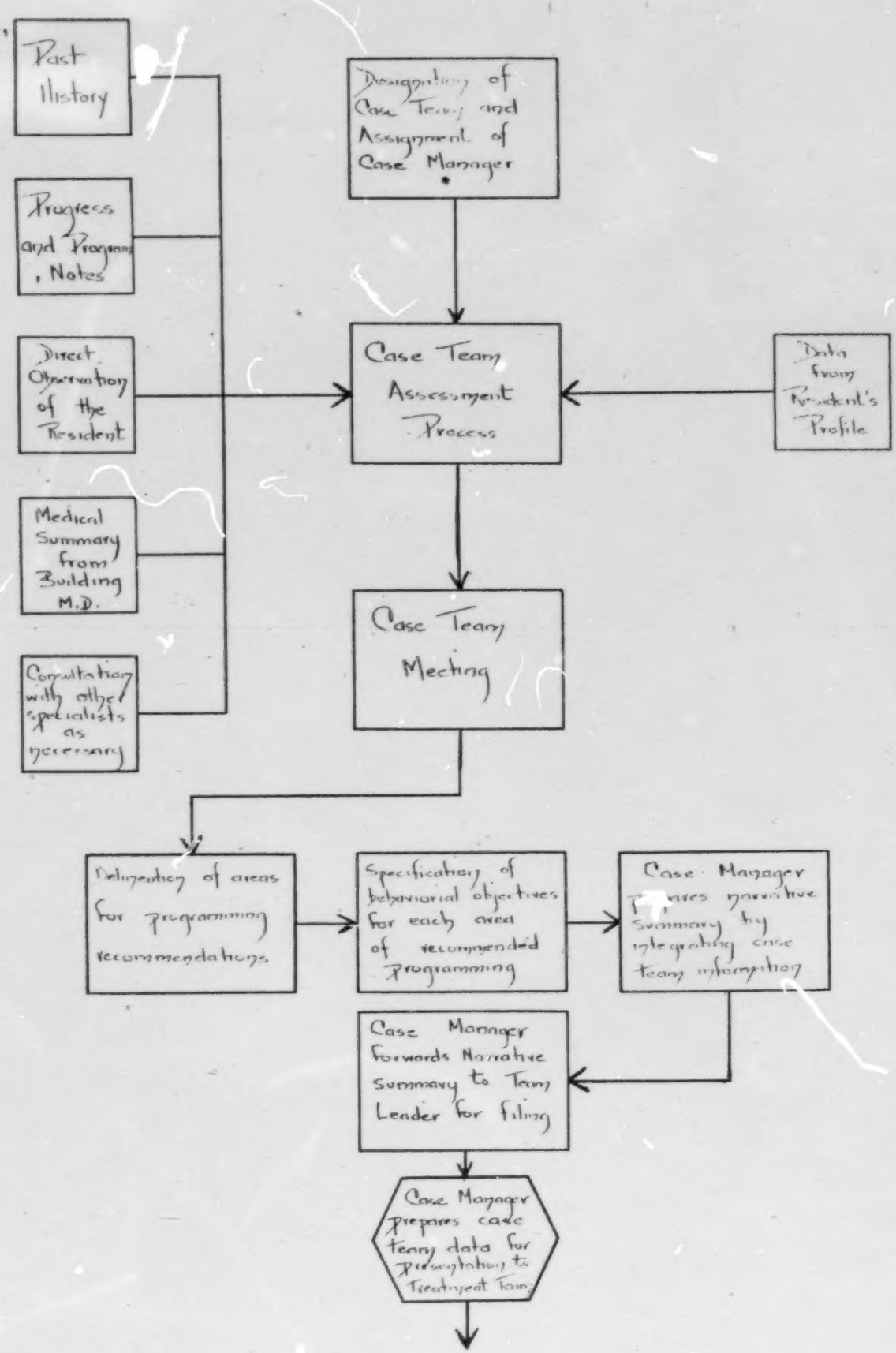
Figure 6. Team Operation - Stage 3. The program implementation stage.

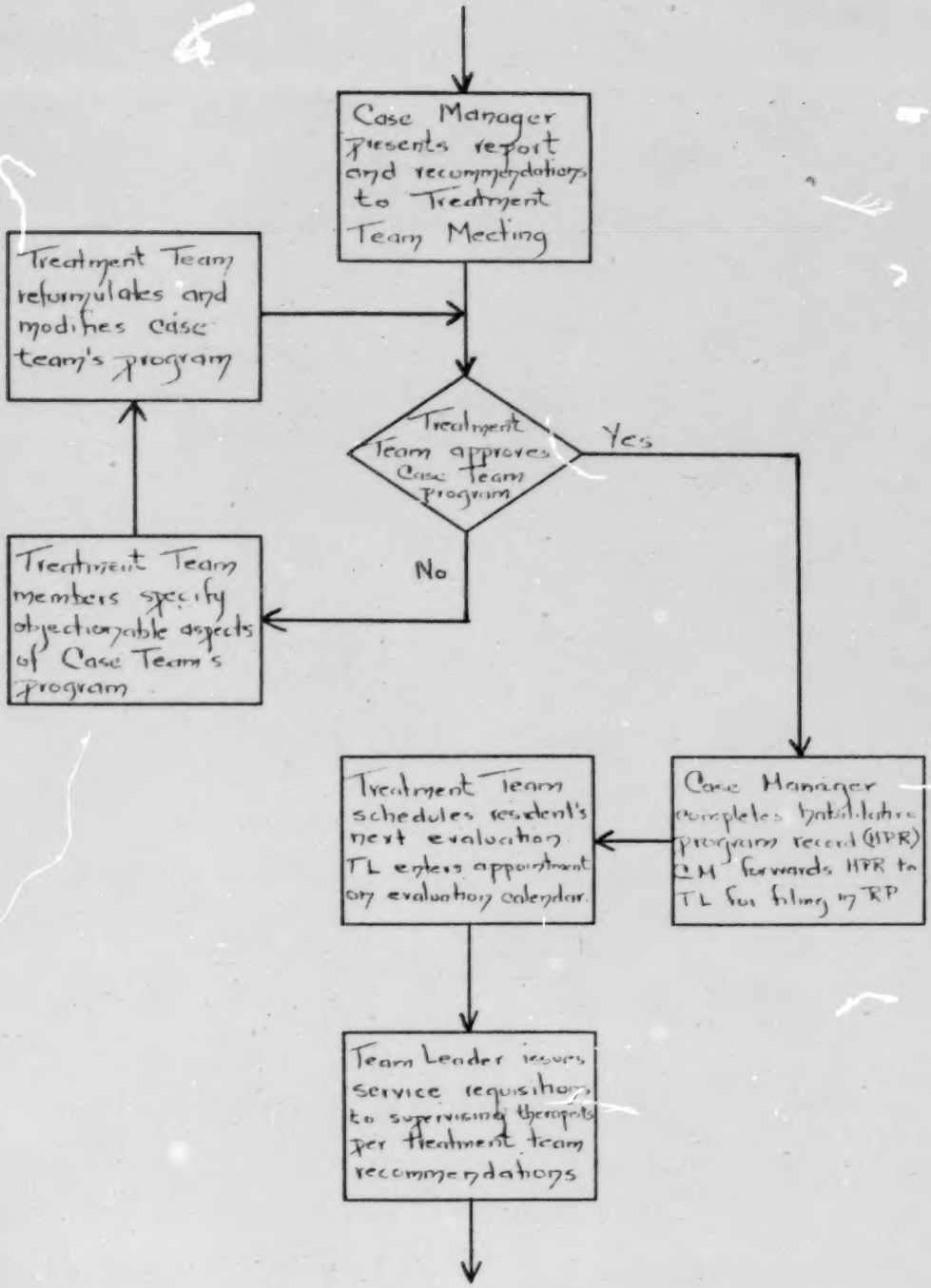
Figure 6. Team Operation - Stage 4. The resident evaluation stage.

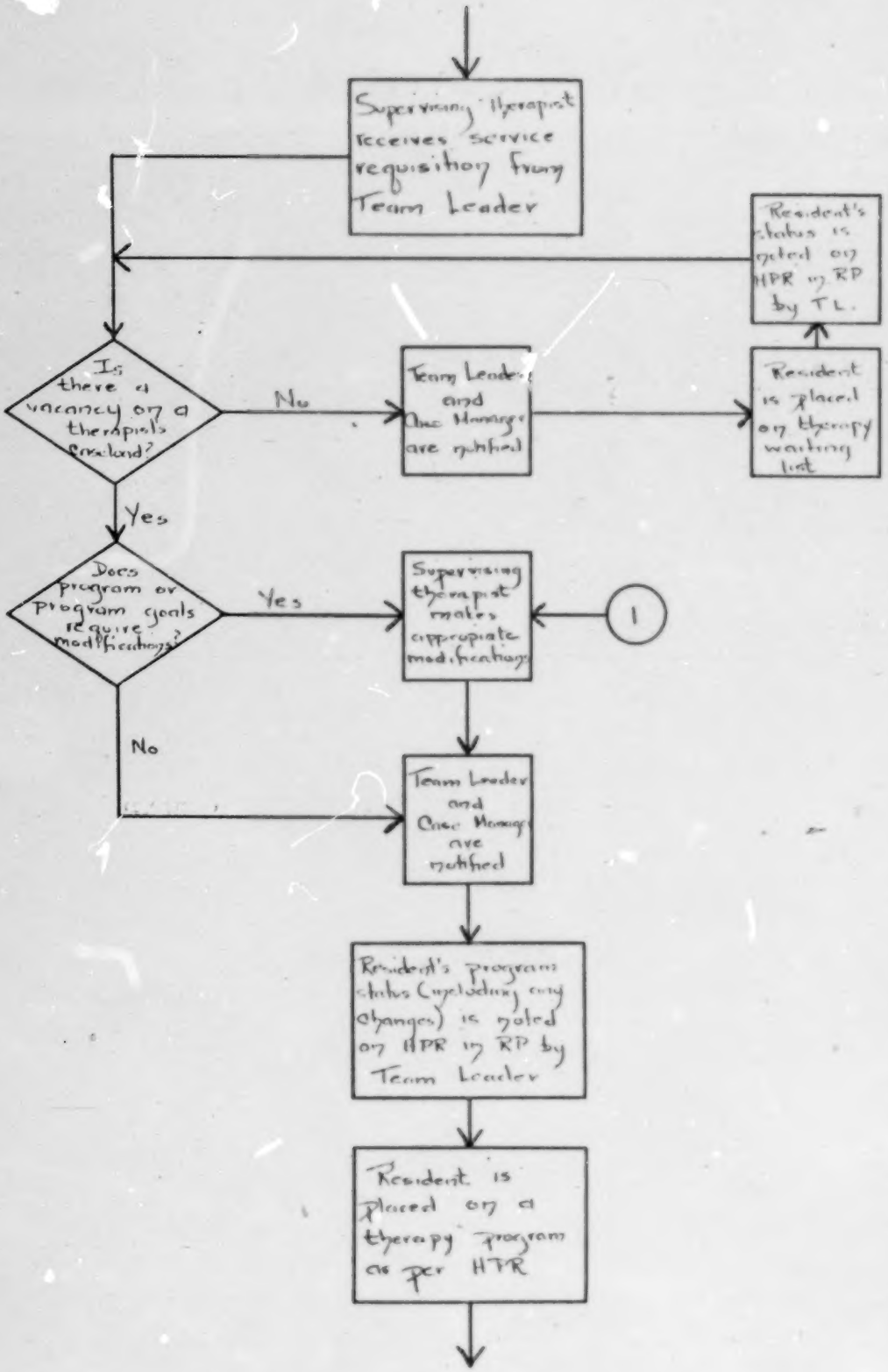

Team Leader
Medical Doctor
Registered Nurse
Education
Occupational Therapy
Recreation Therapy
Physical Therapy
Speech and Hearing
Psychology

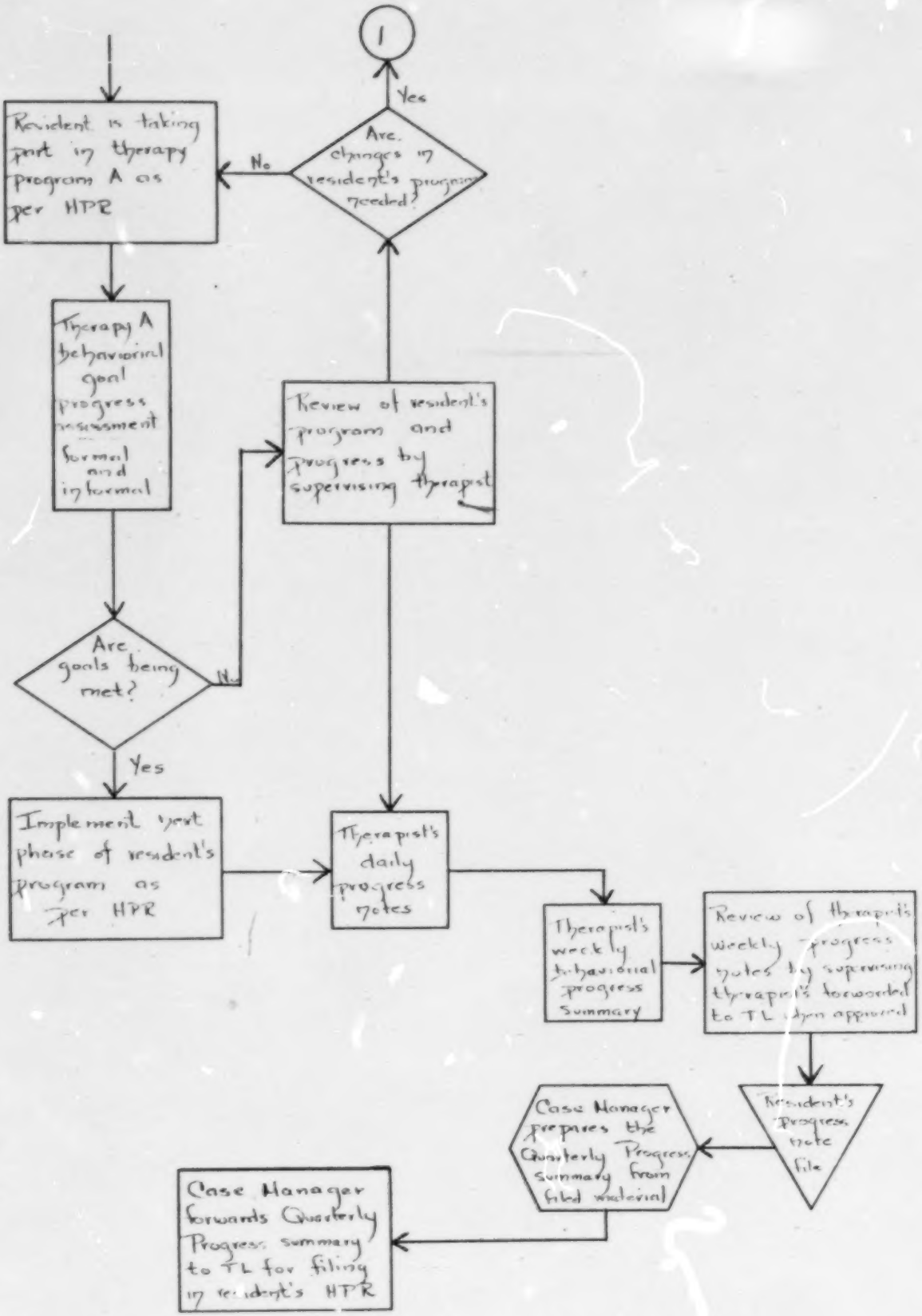

Team Leader
Medical Doctor
Psychology
Case Team 1
Case Team 2
Case Team 3
Case Team 4


Input of all data and documentation about a resident
1
Stage One
Case Team
Assessment
Data File
1
Stage Two
Treatment Team
Consolidation
Data File
1
Stage Three
Program
Implementation
Stage Four
Resident
Evaluation
Data File
1


Past History
Progress and Program Notes
Direct Observation of the Resident
Medical Summary from Building M.D.
Consultation with other specialists as necessary
Designation of Case Team and Assignment of Case Manager
Case Team Assessment Process
Data from Resident's Profile
Case Team Meeting
Delineation of areas for programming recommendations
Specification of behavioral objectives for each area of recommended Programming
Case Manager prepares narrative summary by integrating case team information
Case Manager forwards Narrative Summary to Team Leader for filing
Case Manager prepares case team data for presentation to Treatment Team


Case Manager presents report and recommendations to Treatment Team Meeting
Treatment Team reformulates and modifies case team's program
Treatment Team approves Case Team Program
Yes
No
Treatment Team members specify objectionable aspects of Case Team's program
Treatment Team schedules resident's next evaluation. TL enters appointment on evaluation calendar.
Case Manager completes habilitative program record (HPR) CM forwards HPR to TL for filing in RP
Team Leader issues service requisitions to supervising therapists per treatment team recommendations


Supervising therapist receives service requisition from Team Leader
Is there a vacancy on a therapist's caseload?
No
Team Leader and Case Manager are notified
Resident is placed on therapy waiting list
Resident's status is noted on HPR by TL.
Yes
Does program or program goals require modifications?
Yes
Supervising therapist makes appropriate modifications
1
No
Team Leader and Case Manager are notified
Resident's program status (updating any changes) is noted on HPR in RP by Team Leader
Resident is placed on a therapy program as per HPR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Yes
Are changes in resident's program needed?
No
Resident is taking part in therapy program A as per HPR
Therapy A behavioral goal progress assessment formal and informal
Review of resident's program and progress by supervising therapist
Are goals being met?
No
Yes
Implement next phase of resident's program as per HPR
Therapist's daily progress notes
Therapist's weekly behavioral progress summary
Review of therapist's weekly progress notes by supervising therapist's forwarded to TL when approved
Resident's Progress note file
Case Manager prepares the Quarterly Progress summary from filed material
Case Manager forwards Quarterly Progress summary to TL for filing in resident's HPR